NOTICE OF INDEPENDENT REVIEW DECISION

July 30, 2002

RE: MDR Tracking #: M2-02-0803-01
IRO Certificate #: 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 59 year old male sustained a work related injury on ___ when he was lifting a box and experienced sharp pain in the right hip radiating down his right leg. The patient underwent x-rays of the right hip region and underwent physical therapy. The patient underwent EMG studies on 07/28/01 and a functional capacity evaluation on 03/21/02. The patient continues to complain of pain in the right inguinal region and the treating chiropractor is recommending that the patient undergo biofeedback sessions.

Requested Service(s)

10 biofeedback sessions once a week

Decision

It is determined that the 10 biofeedback sessions at once a week are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

In order to receive admission into a chronic pain management program, according to the Commission of Accreditation of Rehabilitation Facilities (CARF) 1994 Standards Manual, the patient must exhibit benefit from the program design; must have symptoms that meet the description of chronic pain syndrome; and the medical, psychological, or other conditions should not prohibit participation in the program. The patient has already been placed at maximum medical improvement through a designated doctor examination and an independent medical examination thus deeming him to be at pre-accident status. Diagnostic reports exhibit degenerative changes that were part of his medical history prior to the accident and this is probably now the cause of his discomfort. Biofeedback has been shown to be efficacious in migraine patients and not chronic pain patients that have degenerative disc disease and hip arthritis. Therefore, the biofeedback sessions are not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,